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McKnight's LONG-TERM CARE NEWS

Nursing Homes Offering Free Support to Former COVID Residents

Written by: Danielle Brown

2/10/2021

Recovering from COVID-19 isn't the end of the battle for some nursing home residents, particularly those with lingering pulmonary issues. That's why multiple New York nursing homes are ensuring residents dealing with ongoing breathing issues get access to free support groups to help with their post-coronavirus struggles.

"The most important thing is to let the community know that there are free support groups out there like this one for these post-COVID pulmonary issues," explained Lisa Penziner, RN, a special projects director for three skilled nursing facilities.

Six Long Island-based nursing homes are giving seniors access to the American Lung Association's Better Breathers Club as they recover from COVID-19. The group allows cardiopulmonary-disease patients to connect virtually with others facing similar experiences, to learn breathing techniques and receive support throughout their recovery.

"One of the most important parts of recovering from a severe illness is connecting with others in your shoes. These virtual support groups give you the tools you need to live the best quality of life you can," adds Leanne Marinuk, program coordinator for the American Lung Association.

The groups typically meet over Zoom once per month. Residents who have participated in the program credited the tool for being a difference-maker in their daily lives.

Nancy Roeder, who also has chronic obstructive pulmonary disease, contracted COVID-19 in November and believes the disease left her lungs more damaged. She said the techniques she learned while attending the support group through Oasis Rehabilitation and Nursing in Center Moriches, NY, has been key for her recovery.

“My first instinct when I cannot breath was always to bend over, but I have learned that is the worst thing you can do. Sit up straight and don’t panic,” she said.

“After I had COVID, my asthma symptoms came back,” added Lenore DiBlasi. “I had the tightness in my chest and difficulty getting a breath. That’s when I started coming to this group.”

The gatherings could prove to be just the crucial tool that help the patients — and their former providers — breathe easier.

McKnight’s LONG-TERM CARE NEWS

$450 Million for Infection Control, Strike Teams for Nursing Homes in House Bill that Advances

Written by: Danielle Brown

2/8/2021

Nearly a half a billion dollars in funding will be dedicated toward helping nursing homes prevent and limit the spread of COVID-19 in their facilities if the latest measures advanced by House lawmakers for the next pandemic relief package passes.

The House Ways and Means Committee completed its round of markups on President Joe Biden’s $1.9 trillion package late last week. Funding for infection control support to skilled nursing facilities and nursing home strike teams were among the key measures approved by lawmakers as part of the budget reconciliation process.

Specifically, the measures call for $200 million for ensuring SNFs get sufficient help with COVID-related infection control measures through Quality Improvement Organizations. The lawmakers also called for an allocation of $250 million for states to establish strike teams to respond to case surges in SNFs.

The committee said the moves give SNFs the “tools and on-the-ground support they need to contain COVID-19 outbreaks.”

The committee also called for at least $188 million be allocated for the Elder Justice Act in either fiscal 2021 or 2022. The allocation “increases public health and social services to combat abuse, neglect, and exploitation of the elderly that has been exacerbated by the COVID-19 pandemic,” they argued.

Multiple House panels passed their pieces of the coronavirus relief plan last week. House Speaker Nancy Pelosi (D-CA) said she expects the package to be fully approved by the end of February and signed into law before mid-March.

(New article on next page)

McKnight's LONG-TERM CARE NEWS

Fauci: 'Pan-viral' Vaccine May be Needed to Tackle Tenacious COVID-19 Long-term

Written by: Alicia Lasek

2/16/2021

The virus that causes COVID-19 likely is here to stay, and its success in humans means that stronger defense measures will be needed, say Anthony S. Fauci, M.D., and other experts from the National Institute of Allergy and Infectious Diseases.

The virus's ability to rapidly produce variants that infect humans is a "wake-up call" and a sign that a pan-viral vaccine is needed — one that can protect against not only current but yet unknown variants of the virus, the authors wrote in a Friday editorial in *JAMA Network*.

Along with several mutations that the virus now carries, changes to the virus's spike protein are very effective — and concerning, the authors acknowledged.

These variants are moving targets that not only have the potential to reduce vaccine efficacy; they also can wreak havoc on some COVID-19 treatments as well. Among the variants that have scientists most concerned, B.1.351 already may be partially or fully resistant to some of the SARS-CoV-2 monoclonal antibody therapies authorized for use against COVID-19 in the United States, the authors reported. There is also a new strain recently found in California and known as 20C/S:452R, which scientists are watching closely.

There hasn't been much financial support for "pancoronavirus" vaccine research in the past. But the scourge of COVID-19 has spurred action, and work has gotten started on prototypes in animals, according to a New York Times report.

The takeaway? Aside from supporting more vaccine research, scientists and policymakers must commit to detecting and studying all new SARS-CoV-2 variants , the JAMA authors wrote.

Robust surveillance, tracking and vaccine deployment will be needed worldwide, the authors concluded.

***In related news**:*

Coronavirus, like flu, may be here to stay, EU health agency chief says European health officials concur with their American counterparts that SARS-CoV-2, like flu, may be here to stay. "We should be prepared that it will remain with us," said Andrea Ammon, the head of the Stockholm-based European Centre for Disease Prevention and Control, according to Agence France Presse. "It wouldn't be the first virus that is with us forever, so it's not an unusual feature for a virus." The daily COVID-19 case count across Europe has dropped within the last month, from 250,000 to 150,000, according to official data compiled by AFP.

(New article on next page)

Skilled Nursing News

With Infection Control in Spotlight, $237M Program for Nursing Homes Shows Promise for COVID and Beyond

Written by: Maggie Flynn

2/10/2021

Good infection control standards are the same for skilled nursing facilities across the U.S. — both in the sense of federally mandated requirements, and in the sense of the concrete conditions that are necessary to prevent the spread of contamination.

This was true even before a pandemic that shook the world in 2020, with ongoing shockwaves for the U.S. leading into 2021.

While the standards of good infection control are constant, the conditions in which SNF operators have to implement them — and the obstacles to that implementation — can vary wildly depending on their situation.

A small facility with fewer residents and staff, for instance, might find itself with a major COVID-19 outbreak and fewer resources at hand if it is located in a smaller, rural community — while a similarly sized facility in a more urban area, with connections to local hospitals, might be able to contain a similar outbreak through its ties to other providers.

A facility with easy-to-segment wings or floors could find success as a COVID-19 hub for referral partners, while another with a more open-floor plan might struggle to follow the social distancing and isolation protocols required by the pandemic.

The National Nursing Home COVID-19 Action Network (NNHCAN) was established in September 2020 with the goal of trying to level this playing field in terms of the standards themselves, by providing best practices for facilities through training provided by local hubs.

The network is a product of a partnership between the Department of Health and Human Services' (HHS) Agency for Healthcare Research and Quality (AHRQ) and the University of New Mexico's ECHO Institute in Albuquerque and the Institute for Healthcare Improvement (IHI) in Boston. The network was established through an AHRQ contract worth up to $237 million, part of the almost $5 billion Provider Relief Fund authorized earlier this year under the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

When AHRQ embarked on discussions with the various groups and organizations that represent and support nursing homes, staff, medical directors and others, they heard two main requests. One was for continued financial support. The other was for knowledge — specifically making information easier to acquire.

"The knowledge and the information about COVID-19 was changing on an almost daily basis," acting AHRQ director Dr. David Meyers told Skilled Nursing News. "And their focus was so much on caring for their residents, that it was hard to keep up with the changing information. So they pleaded with us and said: Could you make it simpler, so we could get the right information quickly, without having to run to 10 different websites or listen to many, many different phone calls?"

The goal ultimately was to draw information from the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA), he said.

It draws upon the ECHO — or Extension for Community Healthcare Outcomes, model, which was originally developed for primary care, Meyers told SNN. But the ECHO Institute had begun work with nursing homes recently in a project that represents “a massive expansion of what they were doing,” he said.

As of February 3, approximately 8,500 nursing homes are participating in the network, which has 99 training centers across 50 states. These centers operate multiple cohorts, which in turn each serve 25 to 35 nursing homes, on average, according to a spokesperson for the initiative. However, while 8,500 nursing homes have signed up for the network, not all of them have been placed in cohorts yet, she noted.

The first priority was to launch the program and make it available, Meyers said, with about 100 training centers coming online within two months.

“One of the things that excites me the most about this network is that what we’re doing is we’re pairing nursing homes with academic health centers or large hospitals in their areas, who are providing the training and support for them,” he told SNN. “And that’s creating local relationships that will, we hope, go beyond COVID — but also are important not just for COVID in the nursing home, but when patients have to transfer back and [forth], to building trust and understanding and relationships.”

Originally, the program enrollment period was expected to wrap up at the end of the 2020 calendar year, but because AHRQ and ECHO are still seeing interest from nursing homes — both through word of mouth and other means of outreach, such as training centers reaching out to local facilities — that timeline was extended, Meyers told SNN.

Currently AHRQ is recruiting to launch another 20 to 30 cohorts, or learning communities, so any nursing home interested could still sign up, he added.

Skilled Nursing News was able to listen in on one of the training sessions, offered by the Oklahoma Dementia Care Network, part of the University of Oklahoma. The topic was returning to work safely, but that formed only a portion of the session; much of the interaction, both in the chat section of the call and in conversation, consisted of sharing tips and best practices for addressing issues related to maintaining operations in the SNF setting while keeping staff and residents safe.

According to Meyers, this peer-to-peer aspect of the training was critical, given how isolating COVID-19 can be both for individuals and settings generally.

“The nursing home staff, in the day-in and day-out of the work they were doing, it was scary, and people were burning out, and they were feeling very isolated,” he said. “And the first feedback we got from the network was that being on these calls and hearing other nursing homes in their community, people having the same issues, made people feel they weren’t [alone].”

The network is trying to assess the impact of the infection control training course in terms of outcomes and effectiveness, but given the national COVID-19 emergency, coming up with metrics for that was “definitely a second-level priority,” Meyers said. The goal is to eventually assess the changes made and how successful they were, but that will come after the pandemic in a “summative evaluation.”

In the meantime, AHRQ is performing “formative evaluation,” where it holds calls with nursing homes — more than 250 a week — to assess whether the information presented was helpful, and whether it was useful. The curriculum and structure of the training can then be adjusted based on the feedback.

“One of the statistics I’ve gotten to watch is we ask them: Have you made a change? Has it been a big change or a small change?” Meyers told SNN. “And we’ve watched over the weeks, that number is now over 75%, close to 80% of [participating] nursing homes, that have said they’ve made a substantive change in how they’re delivering care for residents as a result of their participation.”

Skilled Nursing News

COVID-19 Shows Need for New Nursing Home Model — But That Won’t Happen Without New Operators, Investors

Written by: Maggie Flynn

2/15/2021

Operators of skilled nursing facilities for years have dealt with the aging post-acute and long-term care infrastructure across the U.S., coping with problems ranging from multi-resident rooms to poor plumbing to outdated building design.

During the COVID-19 pandemic, it became apparent that poor building design was more than a headache for cash-strapped operators; in the case of multi-resident rooms and a lack of places to cohort patients, it could become a matter of life or death.

The clear need for design overhauls and capital expenditures in SNFs, however, does not necessarily mean that they will materialize. For a new model and type of SNF to be more widely adopted, new investors and operators alike will have to emerge, according to Brad Haber, principal and co-founder of Innovative Health — which operates three SNFs in Illinois under its Thrive brand. The company focuses solely on the short-term, post-acute patients, with the facilities self-managed through affiliate ownership entities.

Speaking at Skilled Nursing News’ virtual Payments, Policy, and Capital Summit earlier this month, Haber talked about how the regulatory and investment landscape has shaped — literally — the structure and design of SNFs, and how the pandemic might impact the way buildings are designed and operated in the post-COVID-19 era.

“We think there’s a huge need,” he said at the summit. “The infrastructure’s getting old, and — as our company name indicates — there’s been no innovation in the industry, and we feel like it has to be done. For decades, nothing has been done. And we feel like now is the time. Truly, the past was the time.”

Can you talk how you navigated the financing process for the three Thrive facilities?

In terms of the financing and the regulatory difficulties, in my opinion, the financing side is probably the least of the two difficult things to do. I was in the finance side business for one of the larger lenders for more than 10 years, so the experience I have there has proven to be at least somewhat helpful on the financing side.

But I think there’s a fallacy that lenders are not active in the space. The lenders are active in the skilled nursing space — it’s a select few, it’s the same ones that have been doing it for a while. I think they’re always going to be active in the space.

The challenges are the ones that are active, they have a certain credit box, and if you don't fit that credit box, they're very inflexible in going outside of that. … The lenders that are active, I think they're relationship-driven. So if you've worked with them in the past, they're more inclined to work with you again, especially during the pandemic. If you have not had a relationship with the lenders, then they are really not inclined to start a relationship during this time. It's a difficult time in skilled nursing.

The equity side's a little bit more of a challenge because you obviously have to be more precise. So leverage is one of those key factors. Personal guarantees — all the lenders like personal guarantees, [though] that's the investors' decision on whether they agree or want to do that. Our personal take is we prefer not to do personal guarantees for obvious reasons. Not because we don't trust or support the deal or believe the deal — it's just a philosophy, they would prefer not not to do that.

Then obviously, portfolio transactions are easier. Smaller deals, in my opinion, are probably a little harder to get done as one-off deals; that portfolio effect has a positive effect on getting a transaction done.

In our case, if you're not looking to sign recourse other than carveouts and so forth, the only non-conventional type thing would be HUD [the Department of Housing and Urban Development]. HUD is a great source of debt. The advantages of HUD are: It's great debt, it's long-term debt, it's non-recourse, the terms are pretty nice — because if you want 40 years, the rates are low. It enhances the overall economics of the transaction.

The downside of doing that is the process is it's tedious. It's very hard to get through. It's a lengthy process; it doesn't always work for everyone, especially in the acquisitions phase. If it takes months to get financing complete, and sometimes more than that, a deal might not happen. So once again, there are people out there that will finance in the space. It's not easy, but it can be done.

How about the regulatory process?

The regulatory side, I'd say that's a whole other issue. Our experience on the regulatory side, from Innovative Health's perspective, is really in Illinois. Illinois is a CON [certificate of need] state. Everyone knows CON states, in general, are pretty difficult to develop in. We're ground-up developers, because we don't like some of the more archaic-type buildings; they're not as flexible. We like the newer product, the short-term post-acute side of the business.

In general, the biggest issues are the timing associated with [the CON requirements]. When you go for a CON, the delays can be extensive. Especially in Illinois, the application for a CON — they're not really so specific. It's almost like one CON application fits all projects, whether you're doing a hospital, or an LTAC [long-term acute care hospital], a medical office, or skilled nursing — it's really the same application. So a lot of the difficulty is getting through that approval process.

One example would be: There's a financial section on the CON application that might be [asking for] average days' cash on hand. That's a very relevant fact for a hospital because they need to have — pick your flavor, but say 180 days' cash on hand. There's no skilled nursing operator in this country that's going to have 180 days' cash on hand. So then you're trying to explain to a CON board why you don't have that, and why it doesn't fit the criteria.

Getting through that process is difficult. Getting to that meeting is quite honestly very difficult. It's timely; you can have what I consider a pretty extensive amount of money out there to get to that meeting. A lot of people spend upwards of $200,000, $300,000 or more just to get to that meeting, between attorney fees, applications, time and so forth. You have to have landowners that are willing to option that land for a period of time; if they're not willing to, you have to be willing to take down the land.

So there's a lot of factors that come into play. We at Innovative Health, we like CON states. We like the high-barrier-to-entry model. We'll fight the fight. At the end of the day, once the product is built, we think there's a huge advantage to having those barriers to entry.

The difference from a state like Texas where there is no CON — there has to be a middle ground. Illinois is so restrictive, Texas is not. I think CONs are great; it does limit the overpaying. But that middle ground really has to be met in all these states for everybody.

What has the CON process done in terms of the infrastructure itself, particularly in a more restrictive state in Illinois? How does it contribute to the aging infrastructure problem that's become apparent with COVID-19?

I would say the actual CON regulations don't contribute to that directly. Where it does contribute to it is there are less investors and operators willing to go build new product in the market. So what happens is: There are archaic buildings, and really that's for two reasons.

One — and this will get into an operator's perspective a little bit — people simply just don't have the money to invest into buildings. That's a payment issue, and what the CON laws do — because they limit the ability of new product to come into the market, there's really no reason for people to put money into buildings, because there's no new competitor.

Between not having the reimbursements and not having a new competitor open down the street, there's no return on that investment. So putting that money in really does nothing for you. You could probably go back and do research on when SNFs were approved in Illinois: There was very little capital improvements to buildings that are in that periphery or 10-mile zone around that building. The minute a building gets approved and they start to build it, the competitors will then start to put money into their building, because they want to remain competitive.

The one issue is going to be: It's very hard to maintain that competitive advantage in a building that's 50 years old. On those older buildings, you can make them look nice; you can paint them, you can put new carpet in, you can put new furniture in. But at the end of the day, they were designed very differently. From an operational perspective, they were different. You can't change the walls internally. A lot of them have more … quads or even triples, and that's not the market right now.

So you do have that competitive advantage when you build a new building. But that's really why the product is so archaic: At the end of the day, if you can't build new product, why put the money into it?

Jumping back to that finance side for a second, a common hurdle to new investment that I'd hear cited at conferences and such was the "stroke of the pen" risk, given the SNF sector's reliance on government reimbursement. Is that still something that people are concerned about still, especially since the government has supported SNFs in 2020?

The stroke of the pen risk has been around forever; 15 years ago, when I was financing properties, everyone had that concern. Does it still exist? The answer's yes, and I think people are just either comfortable with it or not comfortable with it.

At the end of the day, how we look at it is: This is an industry that can't go away, there's a need, you have to serve this population. I think we need to serve this population of older people in a better way than we have in the past. The best analogy I can give you is the airline industry; it is essentially too big to fail. You cannot have the airline industry go out of business because that would have a cratering effect on the economy in our country and around the world.

So does it exist? Yes. As you said, 2020 actually proved that more people realize we need to support this industry more than we had in the past. There's tons of stimulus programs out there; the government supported us throughout 2020, providing stimulus money for not only additional expenses — PPE [personal protective equipment] and such, additional wages — but they've done it through programs where you can get reimbursement for dropping census, and the average census is down pretty significantly over the last year, though we think it'll start to go up in the near-term.

2021, I think, will be interesting. I think they're going to have to put some more stimulus out there, because there's no way that a lot of these operators will be able to survive 2021 without more stimulus money. You see reports of 200 or 300 buildings will have to close in 2021 if this continues. They just can't allow that to happen.

Does the pandemic make investment in SNFs more difficult, especially given struggles with occupancy and the question of how permanent diversions to the home health setting are?

I think the last year has definitely brought to the spotlight the need for a new model, there's no doubt. If you ask me what that new model is going to look like — I'll pat ourselves on the back a little bit — you can go and look at our buildings. That's what the new model looks like to us.

I think there's two things you have to look at with these new models. It's the overall infrastructure I talked about, which is more private and semi-privates with bathrooms in every unit for more dignified living. There are other items; everyone talks about new air filtration systems, and so forth. I call that the general bones of the building. Those are the items that you have to plan for up front.

The interior stuff, you can evolve those over time, but at the end of the day, a lot of older SNFs have got air filtration systems that really just recirculate air. In our buildings, air is actually exchanged; fresh air is exchanged with the old air in the building six to 10 times per hour, and the systems are very adaptable.

The other thing — and maybe it's a little bit of dumb luck — we made one of our buildings very flexible, so we've got wings that can be cordoned off or segregated from other populations, and they can use different areas of the building. We were able to use that for COVID, so we were able to segregate these populations, and the nursing staff can be completely separate. Those are things that you can't really change later.

We focus on the short-term, but we actually will partner with some of the long-term care providers, even [independent living] or [assisted living] in the market. Because if they don't have that continuum, we can act as that continuum for them, and residents don't get lost in the system.

This interview has been condensed and edited.